DOCUMENT RESUME

ED 273 859 CG 019 307

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TITLE Models of Service Delivery for the Elderly Mentally Ill.
PUB DATE 26 Aug 86
NOTE 16p.; Paper presented at the Annual Convention of the American Psychological Association (94th, Washington, DC, August 22-26, 1986). For related document, see CG 019 324.
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Delivery Systems; *Health Needs; *Mental Health Programs; *Models; *Older Adults; *Outreach Programs; State Action

ABSTRACT

This paper is concerned with the problem that elderly persons do not seek or receive mental health services as frequently as their numbers or the incidence of mental health problems would indicate is appropriate. The report focuses on the identification of innovative mental health service delivery programs which have been designed to reach and to help the elderly. Several data collection procedures used to obtain information about model programs of this kind are described, including a literature review, telephone contacts with authors of model programs, inquiries to the Office of Aging to learn about federally-funded projects, telephone contacts with state offices of aging and offices of mental health, and a snowball sampling technique. Prior studies of model mental health programs are reviewed, state-level initiatives are described, and 10 services needed by the elderly are listed. Nine conclusions drawn from the review of model programs are presented and nine characteristics of innovative programs are noted. A summary section contains ideas for possible directions for Pennsylvania to take in the delivery of mental health services to the elderly in the areas of; (1) education; (2) packaging; (3) specialized services; (4) variety of services; (5) prioritizing disorders; (6) local initiative; (7) organizational linkages; (8) cross training; (9) lead agency; (10) program evaluation; and (11) service delivery models. Future directions and research plans are discussed. (NB)

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MODELS OF SERVICE DELIVERY FOR THE ELDERLY MENTALLY ILL

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CG 019307

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Presented to the American Psychological Association, Washington, D.C., August 26, 1986.

While it has been generally acknowledged that elderly persons do not seek or receive mental health services as frequently as their numbers or the incidence of mental health problems would indicate is appropriate, the reasons for this failure have not been entirely clear. It has been suggested that mental health problems among the elderly are not recognized as such either by the elderly or by service providers because of the difficulty of distinguishing between emotional and physical causes of illness among the elderly; that isolation, limited mobility, low income and other factors which characterize large numbers of the elderly population inhibit their full access to available services; and that the historic division of responsibility for aging and mental health services between separate organizational structures all function as barriers to meeting the mental health needs of the elderly.

This report focuses on the identification of innovative mental health service delivery programs which have been designed to reach and to help the elderly.

Model Programs

Data Collection Procedures

Several mechanisms were used to obtain information about model programs for the delivery of mental health services to the elderly. These included, (a) a literature review of published reports on geriatric mental health services, (b) phone contacts with authors of several model programs described in the literature, (c) an inquiry to the Office of Aging in Washington, D.C. for leads on federally funded projects, (d) phone contacts with a sample of 15 state level offices of aging and 15 offices of mental health, and (e) a snowball sampling technique in which each contact person

was asked for leads to other innovative programs. This process permitted us to have at least one contact with nearly every state in the country.

Prior Studies of Model Mental Health Programs

One prior review (referred to here as The Kentucky Study; Roeder, 1981) described the characteristics of model programs as of 1980. The following conclusions were drawn in that review: (a) neither the mental health network nor the aging network is very involved in geriatric mental health services, (b) there is confusion about which network has the responsibility for providing these services and about what the services should include, (c) the aging network tends to focus on the well-elderly and the mental health network focuses on the chronically mentally ill, (d) the mental health network has been faced with a serious decline in resources which decreases the chances of new services being developed, (e) there is a lack of trained professionals in both networks who are knowledgeable in geriatric mental health, (f) in urban areas, coordination of existing services is more of a problem than lack of resources; the opposite is true in rural areas, and (g) there are glaring exceptions to these generalizations, and model programs are beginning to surface.

According to the Kentucky study, exemplary geriatric mental health programs have some combinations of the following characteristics: (a) multidisciplinary team approach, (b) outreach (case finding), (c) comprehensive assessment and intake procedures, (d) case management (follow-up), (e) specialized services for the elderly, (f) critical mass of staff, budget, and clients, and (g) visibility and status within the broader mental health network and within the community, although often without the traditional mental health label. In addition, their site visits suggested that the success of at least some local programs had been

dependent on strong and sustained efforts by both state and community agency administrators to initiate and develop effective programs and upon the successful participation of the elderly in state and local politics.

State-Level Initiatives

The phone contacts with offices of aging and offices of mental health at the state level were instructive. Officials were asked to describe any model programs in their state or any ongoing projects coordinated or funded at the state level. Approximately one-half of the states contacted reported that there was some activity underway either to study the mental health needs of the elderly or to increase services to them. The remaining states reported that there was no particular attention being given to this issue, although, almost without fail, the informant agreed that the elderly have mental health needs which remain unmet.

Varieties of Services Required

The literature documents that a variety of services will be necessary to meet the mental health needs of the elderly. A comprehensive mental health system for the elderly would offer such traditional services as crisis intervention, diagnosis, and treatment. These services would be designed to be accessible, visible, and acceptable to older persons. Geriatric mental health specialists would be available to serve the elderly clients at the agency.

However, it is also obvious from rates-under-treatment data that the majority of elderly persons with mental health problems do not use these traditional services. Additional specialized services and methods of service delivery are needed. Several such services were identified in this study. They are listed here as distinct entities, although in reality they are usually a part of a broader package of services.

a. Mutual Help Groups

b. Peer Counseling

c. Information and Referral

d. Case Finding

e. Case Management

f. Assessment Centers

g. Supervised Living Arrangements

h. Advocacy, Education, and Consultation

i. In-Home Assessment and Treatment

j. Comprehensive, Integrated Services

Review of Model Program

Our review of model programs for the elderly drew the following conclusions:

(a) most states have no central program plans for evaluating or meeting the mental health needs of the elderly,

(b) the majority of existing mental health programs for the elderly have developed out of local initiatives,

(c) there is confusion within both aging and mental health as to which agency should be responsible for the delivery of mental health services to the elderly,

(d) there is little linkage or cross-fertilization between the staffs of aging offices and mental health offices from the state level down to the local level,

(e) most existing mental health delivery programs for the elderly are narrowly focused on either a specific service (e.g., peer counseling, assessment centers) or on a specific subgroup of

elderly (e.g., bereaved elderly, high risk elderly),

(f) both mental health and aging offices express hesitancy about expanding their services into the geriatric mental health arena,

(g) in many instances, state-level offices of mental health and aging do not know what the other is doing in geriatric mental health,

(h) isolated successful programs that now exist may not be easily transplanted to different environments (e.g., A program in Pennsylvania found it difficult to establish a peer counseling program although a program in Santa Monica, California, is thriving), and

(i) very few existing projects have given serious consideration to program evaluation, and it is therefore impossible to draw conclusions about the effectiveness of most innovative programs.

Several characteristics of innovative programs can also be noted. Examples of innovative programs include:

(a) extensive outreach and consultation,

(b) nontraditional services and delivery methods,

(c) a multidisciplinary team approach,

(d) specialized services for the elderly,

(e) ongoing training and supervision for both mental health and aging staff members,

(f) Linkages between aging and mental health,

(g) local enthusiasm for needs and services for the elderly,

(h) specialized intake/assessment procedures, and

(i) case management or service management.

Summary and Recommendations

What follows are ideas for possible directions for Pennsylvania in the delivery of mental health services to the elderly. Some of these ideas are designed to raise questions which need to be addressed by the Department of Aging and the Office of Mental Health. In other instances the ideas are presented more as conclusions drawn from the literature review and the data collected in the needs assessment.

1. Education. The major barriers to use of mental health services by the elderly need to be reduced. Without removing the barriers, specialized services will not be used by those elderly most in need. How can this be done? The most obvious answer is through education of the community, especially the elderly. However, efforts to educate the public about mental health issues have been underway for a long time apparently without much effect on the elderly (e.g., local chapters of the Mental Health Association and other similar organizations). Education programming may have to be directed specifically to the elderly and their families.

2. Packaging. A second and potentially more immediately effective strategy to reduce barriers would be to package mental health services to the elderly in non-traditional ways, such as in-home services or mobile assessment teams.

3. Specialized Services. Specialized services for the elderly should be developed for the mental health service delivery system. Specialized services refers both to unique ways of

finding new cases and delivering services and to developing improved treatment procedures for mental health problems. This project has emphasized the first of these forms of specialized services. However, we are also aware that specialized treatment regimens are now available to treat the elderly for problems of depression, loneliness, insomnia, etc. Mental health service providers should receive training in these specialized services.

4. Variety of Services. The variety of specialized mental health services available to the elderly should be increased. Our review of programs across the country impressed upon us the fact that few places offer more than a very few special services for the elderly. Yet the literature repeatedly stresses that the problems of the elderly are almost always multifaceted. Providing one or two unique services is not likely to have much of an impact on the mental health of the population.

5. Prioritize Disorders. The mental health problems of depression, thinking and memory disorders, and anxiety related disorders should be specifically targeted as priority areas.

6. Local Initiative. Local initiative for innovative programming for the elderly should continue to be encouraged. Most model programs in the country have made effective use of local elderly citizens and local advocacy.

7. Organizational Linkages. The development of interagency agreements between aging and mental health from the state level to the local level seems very appropriate. The mental health

system in Pennsylvania is primarily decentralized to the county level. This arrangement typically places the responsibility for program development on the local programs. While local enthusiasm and initiative are vital to the development of elderly mental health services, this decentralized style may leave large gaps in services at the local level and produce significant county-by-county variations in quality of services. Local programs are may not be sufficiently aware of new program developments in the county, and many county programs may not initiate any specialized programs for the elderly if such services are not mandated.

Multiple linkages between the aging and mental health systems at the local level will help to remove barriers between these service providers. These linkages may include such things as producing joint projects, reviewing each other's budgets, having memberships on each other's advisory boards, etc.

8. Cross Training. Training for the staff of both mental health and aging systems on the topics of geriatric mental health should be expanded. Most surveys of staff knowledge have concluded that the majority of mental health professionals have received little or no training in the unique mental health needs of the elderly nor on the specialized services that are needed to address the problems of the elderly. Equally, aging staff often are found to lack knowledge about mental health issues, and have not been trained to identify mental health problems in the elderly. The staff of both systems have

reservations about the other and about the appropriateness of the services of the other. Joint staff training might reduce these barriers.

9. Lead Agency. Clarify whether aging or mental health should be the lead agency in developing geriatric mental health services. Our review of model programs revealed that both agencies have been able to assume this role. However, almost all integrated, comprehensive programs have developed an organizational structure somewhat independent of the existing mental health and aging systems. Surveys of aging and mental health service providers have uncovered disagreements about which agency should assume the lead. Our needs assessment clearly identified a stigma against mental health problems and treatment, and traditional mental health services have not been used by the elderly. At the same time aging service providers have not been eager to assume expanded duties into the mental health arena. Aging services do have the lead in case management services which is a badly needed specialized service for the elderly. The ongoing demonstration projects in Pennsylvania may also be able to address this question. Several of the projects are emphasizing a "shared client" mechanism in which aging and mental health share information on clients. One project has completed a joint intake form for both agencies. Finally, it should be noted that two models of case management have been proposed in the literature. These are the Central Intake Model and the Multiple Entry Model. The Multiple Entry Model may be appropriate to Pennsylvania. In

this model, clients may enter the health system (e.g., aging, mental health) at multiple points, but in every case a common intake process is followed and a treatment plan is devised and a case manager is assigned. Individual service providers may then flesh out their components of the treatment plan, but this additional information is relayed back to the case manager who can oversee the entire package of services delivered to the elderly client. This single case manager can coordinate all of the paperwork for the client, reduce the chances that a given client will be overlooked by other services, and provide continued contact when a given service is terminated. In our opinion, the question of which system is the lead agency is less crucial as long as a case management system is instituted which integrates all services for the elderly. By the same token, mental health service delivery will likely not improve if many of the aging and mental health services are not integrated. The elderly are not going to become sophisticated users of a complex maze of services.

10. Program Evaluation. When specialized services are provided, their effectiveness should be routinely evaluated. Program evaluation data are embarrassingly lacking from most innovative programs in the country. Decisions about which specialized programs should be fostered should ideally be based on evidence that the specialized programs are effective.

11. Service Delivery Models. To the extent that aging and mental health must coordinate and integrate services, system differences must be addressed. Some of the system differences

which serve as barriers include differences in the lower age cut-off for definition of elderly (age 60 or 65), funding for services (e.g., in-home visits are not easily reimbursable to mental health, but Michigan has apparently worked around this barrier, and waivers of some regulations from some funding sources may be available), differences between aging and mental health in boundaries of the catchment or service delivery areas, differences in service delivery philosophy (e.g., aging: "go find them"; mental health: "let them come and get it").

Future Directions

Based on these and other data we believe that the next step is to implement programs for the elderly that are multifaceted, comprehensive, and integrated. Such services must pay special attention to case finding, case management, specialized services, and well-trained staff. The few such programs now in existence have been housed in administrative settings independent of mental health and aging. They have set up their own administrative structure which has then drawn funds from mental health and aging. But, this is a very expensive model of service delivery, but if it is the only way to assure that appropriate services will be delivered to the elderly, then it may be worth it. However, it is also possible that a good traditional mental health service delivery system could be modified sufficiently to provide equivalent services. We have submitted a preproposal to NIMH to test this question. Our research would experimentally compare two models for delivering mental health services to the elderly. The

models are called the Traditional Model and the Therapeutic Case Management Model.

The Traditional Model of service delivery will consist of an excellent example of a traditional mental health delivery system in Pennsylvania. It is our intention to chose a site where mental health staff are already well trained in clinical gerontology and where relationships between the mental health system and other service delivery systems for the elderly are well developed.

The Therapeutic Case Management Model will be an extension of existing model programs and it will add several features which represent the state of the art in service delivery. Key elements will include ongoing case management, in-home assessment and counseling services, and integration of aging and other service systems into the treatment plan. The model is called Therapeutic Case Management to emphasize that case managers will also provide psychotherapy.

Aggressive case finding mechanisms will be used in the target community. Clients at all levels of risk will be randomly assigned to one of the two groups.

Experimental and quasi-experimental comparisons will include (a) the number and rates of cases referred for mental health treatment in the community under study as compared to its own performance during a previous time period and to other similar communities statewide; (b) the number and types of aging and mental health services delivered to clients in each model and overall in the study community compared to its previous experience and the experience of other communities statewide; (c) levels of

functioning and satisfaction of clients of each model; (d) rates of use of nursing homes, acute hospitals, and other forms of more extensive care; (e) marginal costs of each model compared to each other, to the community in previous years and to other statewide communities; (f) evaluations of which types of client mental health problems are most effectively treated by each model.

Our study proposes to make a scientifically rigorous test of two major alternatives for delivering mental health services to the elderly. In addition, we will evaluate which types of client problems are most effectively treated in each model. Results of this research will provide guidance for federal policy regarding the promotion of mental health programs for the elderly. It will also address the issue of how local programs should proceed in developing better mental health services to the elderly while remaining cost effective.

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